INITIAL EVALUATION SUMMARY

Claims Administrator:	Employee:	
Address:	Claim #:	DOI:
City/State/Zip:	Employer:	
Contact Name:	Date of Initial Evaluation:	

Reason for Referral:

☐ Full Service ☐ Evaluation Only

Initial Meeting and Impressions: Vocationally Feasible? ☐ Yes ☐ No ☐ Deferred (Explain)

Summary:

Recommendations:

Plan of Action:

Next Reporting Date:

QRR (print name):	Signature:	Date:

Telephone Number:

Attachments:	Copies Sent To:
a) Data Sheet	a)
b)	b)
c)	c)
d)	d)
e)	e)

INITIAL EVALUATION DATA SHEET

PERSONAL INFORMATION: Name:

☐ Male ☐ Female	Social Security No.:	DOB:
Phone No.:	CA Driver's License No.:	Exp. Date:

License Restrictions (Explain):

Distance willing to travel to work (one way):	Areas willing to drive:

Reliable vehicle available for transportation (full-time): ☐ Yes ☐ No
If no, what method of transportation will be used?

Willing to relocate? ☐ Yes ☐ No	Work Shifts: ☐ All Days ☐ All Shifts ☐ M-F Only ☐ 8-5 Only

Describe issues which may interfere with employee's participation in services:

SOCIO-FAMILY FINANCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Number of Dependents Living at Home:	Ages:	Child Support Payments? ☐ Yes ☐ No Amount: $
Child care required: ☐ Yes ☐ No	Estimated amount per week: $	

Able to financially support self throughout duration of services: ☐ Yes ☐ No (Explain):

Receiving VRMA? ☐ Yes ☐ No	Amount per week:$
Receiving PD Supplement? ☐ Yes ☐ No	Amount per week:$

Other sources of income (explain):

EDUCATIONAL BACKGROUND

High school graduate? ☐ Yes ☐ No Year:	Name & Location of High School:
If not HS graduate, GED? ☐ Yes Year: If no GED, Last grade completed:	Post-HS Studies: ☐ Certificate ☐ AA/AS ☐ BA/BS Year: Area of Study:

English Language:				Other Language:			
Speak	☐ Yes	☐ No		Speak	☐ Yes	☐ No	
Read	☐ Yes	☐ No	Level:	Read	☐ Yes	☐ No	
Write	☐ Yes	☐ No	Level:	Write	☐ Yes	☐ No	

Employee's List of Perceived Work Skills:

MILITARY SERVICE: Dates of Service: Branch:

Special Skills:

VOCATIONAL HISTORY

Company & Location	Dates Employed From	To	Job Title	Salary	Reason for Leaving

MEDICAL FILE REVIEW

Treating Physician: Phone:

Address:

Injury/Diagnosis:

Permanent & Stationary: Yes No Date:

Medical Restrictions/Limitations (specify medical report and date relied upon):

Current Medications (specify medical report and date relied upon):

Currently in Physical Therapy: ☐ Yes ☐ No Days/Times:

Non-industrially Related Medical Conditions (explain):

PRESENT PHYSICAL TOLERANCES (Subjective)

Sitting: _____ minutes
Standing: _____ minutes
Driving: _____ minutes
Walking: _____ minutes
Vision Restriction: ☐ Yes ☐ No

Lifting: ☐ Can ☐ Cannot
# of Pounds: ____
Climb steps: ☐ Can ☐ Cannot
Bending: ☐ Can ☐ Cannot
Dominant Hand: ☐ Right ☐ Left

Reaching:
Below shoulder ☐ Yes ☐ No
At shoulder ☐ Yes ☐ No
Handling/Feeling ☐ Yes ☐ No
Pushing/Pulling ☐ Yes ☐ No

Ready to Return to Work: ☐ Yes ☐ No

Supplemental Medical/Physical Information:

VOCATIONAL CONSIDERATIONS

Preliminary Assessment of Transferable Skills:

Client's Expressed Interest/Expectations of Vocational Rehabilitation:

Observations (Comments on appearance, rapport, cooperation, attitude):

VOCATIONAL FEASIBILITY FACTORS

Can the employee reasonably benefit from the provision of vocational rehabilitation services?

INVESTIGATION OF MODIFIED/ALTERNATIVE EMPLOYMENT

☐ Available	Contact:
☐ Not Available	Title:
☐ Unknown/Not Requested	Date of Conduct:

EXPLANATION OF VOCATIONAL REHABILITATION PROCESS
(Check Box for all Issues Covered with Employee)

☐ EE Role	☐ Caps/Limits on VR	☐ Termination Process
☐ QRR Role	☐ VRMA	☐ Reinstatement Process
☐ Carrier/ER Role	☐ Dispute Resolution Process	☐ Interruption Process
☐ Rehab Unit Role	☐ Effect of Delays	☐ Allowable Costs
☐ Help RTW Brochure	☐ Plan Definition	☐ Nature/Extent of Added Costs
☐ Plan Hierarchy	☐ Plan Parameters	☐ Other (Explain)

Rehabilitation Unit
California Division of Workers' Compensation

Form RU-120

INITIAL EVALUATION SUMMARY

Purpose:
To document the findings and recommendations of the Qualified Rehabilitation Representative who conducts the initial evaluation. Per AR Section 10132.1, such assessment is to include an initial assessment of the worker's ability to benefit from VR services.

Submitted by:
Qualified Rehabilitation Representative (QRR).

When submitted:
The Rehabilitation Unit encourages an expeditious assessment of employee skills and vocational feasibility. The RU-120 should be submitted not later than 30 days from completion of the initial interview, unless otherwise agreed to.

Where submitted:
To the claims administrator with copies to all parties. If the QRR were functioning as an Independent Vocational Evaluator (IVE), the RU-120 would be filed directly with the Rehabilitation Unit with copies to all parties.

Form completion:
This form is to be completed by the QRR. The purpose of the form is to obtain comprehensive, yet concise, information which is critical for assessing vocational feasibility and developing an appropriate plan per the California Standards Governing Timeliness and Quality of Vocational Rehabilitation Services. Information gathered for each section must fit within the section designated for that category and the typeface must be no smaller than 10 point. The cost of additional or more detailed reports must be borne by the party requesting them.

Accompanying documents:
None.

Rehabilitation Unit action:
None.

Copy:
All parties.